DEMOGRAPHIC CHANGE FORM

Submit this form to your employer to make changes in your and/or your dependents' contact information or name. The information on this form will replace any prior information that you have submitted for your WCIF benefits.

THIS FORM IS TO REGISTER A CHANGE FOR (check one):

☐ **Employee Address Change** | ☐ **Dependent Address Change** | ☐ **Change of Contact Information** | ☐ **Name Change**

EMPLOYER SECTION

Employer Name:		BSI Account #:	Class Code *(if applicable)*:
Approved by *(administrator name)*:	Date Approved:	Special Note(s) / Direction(s):	

EMPLOYEE INFORMATION

NEW / CURRENT INFORMATION

Name *(First, Middle, Last)*:			Social Security Number:	
Address:		City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Email Address:	

PREVIOUS INFORMATION (if making a change)

Name *(First, Middle, Last)*:			Social Security Number:	
Address:		City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:	Email Address:	

DEPENDENT INFORMATION

NEW / CURRENT INFORMATION

Name *(First, Middle, Last)*:		Social Security Number:	
Address:	City:	State:	Zip:

PREVIOUS INFORMATION (if making a change)

Name *(First, Middle, Last)*:		Social Security Number:	
Address:	City:	State:	Zip:

SIGNATURE

This form replaces all previous forms and submissions I have made for WCIF benefits.

Employee's Signature: ______________________________ Date: ________________